STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155719	A. BUILDING 00 B. WING	11/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE ADE MEMORIAL HEALTH CARE CENTER	3623 E SR 16 BROOK, IN47922

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: October 31, and November 1, 2, 3, 2011 Facility number: 000559 Provider number: 155719 Aim number: 100267170 Survey team: Regina Sanders, RN-TC Kelly Sizemore, RN Marcia Mital, RN Sheila Sizemore, RN Census bed type: SNF: 01 SNF/NF: 54 Total: 55 Census payor type: Medicare: 09 Medicaid: 18 Other: 28 Total: 55 Sample: 14 Supplemental sample: 5 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Re: POC for the annual survey of George Ade Memorial Health Care Center, Brook, IN. Survey Event ID 6VUC11Dear Miriam Buffington:This letter is in regards to the aforementioned survey that was conducted on November 3, 2011. The following plan of correction is being submitted as our allegation of substantial compliance. We further submit that this facility is in substantial compliance as of the 18th day of November 2011. After that time we are requesting the Indiana State Department of Health conduct a follow-up survey and/or accept this information for paper compliance to clear the findings and stop any and all proposed or implemented remedies that have been presented to date. If you have any questions or need further information, call 219-275-2531 or fax 219-275-7472, and we will be available to assist you in any way possible.Thank you,W R Scott James, HFAGAMHCCThis plan of correction is prepared and submitted solely because it is required by the State and Federal law, and not because the Provider agrees with the allegations made in the survey document. In fact, the alleged deficiencies do not, either individually or collectively, demonstrate that the facility's residents health, safety or welfare	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed 11/7/11 Cathy Emswiller RN		is compromised or that this Provider is incapable of rendering all necessary and beneficial nursing care and services. This plan of correction constitutes the Provider's allegation of compliance. Completion dates are provided because they are required by State and Federal law, and to correlate with accomplished correction action, in the context of the survey process. To the extent possible, permissible dates, i.e. dates after the surveyors left the facility, were assigned. ·Addendum's to submission response are bullet pointed in all responses.	
F0280 SS=E	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review and interview, the facility failed to ensure residents' care plans were developed and updated, related	F0280	It is the practice of the facility to develop and maintain a comprehensive plan of care for each resident and their individual	11/18/2011

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	to skin conditions, medications, dietary supplements, a death of a family member, and an urinary catheter for 4 of 14 residents reviewed for care plans in a sample of 14. (Residents #4, #23, #37, and #38) Findings include: 1. Resident #38's record was reviewed on 11/02/11 at 10:40 a.m. The resident's diagnoses included, but were not limited to, hypertension and stroke. A physician's telephone order, dated 10/23/11, indicated an order for Benadryl (antihistamine) and hydrocortisone cream (for itching) due to a rash. The resident's physician's recapitulation orders, dated 11/11, indicated an order, dated 10/21/10 for Plavix (blood thinner) daily. There was a lack of documentation in the resident's record to indicate a care plan had been initiated for the resident's rash and Plavix usage. During interviews on 11/02/11 at 11:20 a.m., RN #1 indicated the resident still had a faint rash and they were still treating the area and the MDS Coordinator indicated there were no care plans for the rash and the Plavix.		needs. This is done by an interdisciplinary team and reviewed and revised as the residents care needs changed.For conditions not expected to last more than 14 days, a short term care plan will be established defining the residents temporary problem, our interventions and expected goals. If after 14 days the problem persists, it will be converted to a comprehensive care plan.The care plan has been updated for resident #38 to include Plavix, completed on 11/2/2011. A care plan has also been written for history of rash/skin irritation. A care plan has been implemented for resident #23 for a foley catheter.A care plan for resident #4 has been updated by the Dietary Manager, along with a dietary note on 11/1/2011.A care plan for resident #4 was updated by Social Service as of 11/1/2011.Thus far 53 of 53 charts have been reviewed as of 11/16/2011 for care plan accuracy.An in-service was held for Nursing Staff on 11/16/2011 defining this policy and the new processes and their implementation.Effectiveness will be monitored by DON, Restorative Nurse, and MDS nurse three times a week for two weeks, then two times a week for two weeks, and then one time a week for two weeks. Refinements and modifications will be implemented as deemed	

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	2. Resident #23's record was reviewed on 10/31/11 at 11:55 a.m. Resident #23's diagnoses included, but were not limited to MRSA (methicillin resistant staph aureus) in urine and Alzheimer with dementia. A physician's telephone order, dated 10/24/11 at 3:00 p.m., indicated Resident #23 was to have a foley catheter anchored in place for 10 days due to MRSA in her urine. Review of Resident #23's care plans and acute care plans, dated 10/22/11 and 9/2/11, lacked documentation of a care plan for the resident's foley catheter. During an interview on 10/31/11 at 12:50 p.m., LPN #2 indicated a care plan should have been completed on the day the foley catheter was ordered by the physician' During an interview on 10/31/11 at 1:40 p.m., the MDS Coordinator indicated the		necessary.Audit and review information will be presented at bi-montly QA meeting.This is done as of 11/18/2011. ·Care plan updated on 9/27/2011 for resident #37, use of short term care plans were reviewed on 11/16/2011 with nursing staff, to prevent further concern.	

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	foley catheter order should have been picked up and put on an acute care plan. 3. Resident #4's record was reviewed on 11/1/11 at 9 a.m. Resident #4's diagnoses included, but were not limited to, seizure disorder and blind in right eye. A physician's order, dated 8/26/11, indicated "Dc (discontinue) megace (appetite stimulant)...med pass (supplement)..." A care plan, dated 8/08 and updated 7/11, indicated "...potential for altered nutrition status related to...poor oral intake...approach...13) Provide Med Pass per order. 14) Appetite stimulant per order...." During an interview on 11/1/11 at 9:35 a.m., the Dietary Manager indicated the resident's care plan needed updated. Resident #4's social service notes, dated 10/5/11, indicated "SSD (Social Service Director) notified at home that resident's mother/roommate passed away this evening..." A care plan, dated 4/23/09 and updated 1/15/10 and reviewed 08/25/11 by the facility, indicated "...Resident prefers time to visit with mother who is resident also and will attend activities that mother will			

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	attend..." A care plan, dated 3/10/11 and updated 8/18/11, The resident at time (sic) has hx (history) of resisting care and often refuses to allow anyone to care for her other than her mother..." During an interview on 11/1/11 at 1:49 p.m., LPN #7 indicated the resident's care plans needed updated related to her mother passing away. 4. Resident #37's record was reviewed on 10/31/11 at 12:20 p.m. Resident #37's diagnoses included, but were not limited to, wound to heel, diabetes mellitus, and hypertension. A nurses' note, dated 9/17/11 at 11:30 p.m., indicated "Res (Resident) c/o (complained of) tenderness to Rt (right) heel area. Noted red area with white center, tender to touch..." The resident's record lacked documentation of a care plan for the resident's heel until 9/27/11. During an interview on 10/31/11 at 1:50 p.m., LPN #3 indicated she had found the areas on the resident's heel on 9/17/11. She indicated she had not put a care plan into place.			

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	3.1-35(c)(1) 3.1-35(d)(2)(B)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure physician's orders were followed related to skin protectors and sliding scale insulin orders (insulin administered per the resident's blood sugar results) for 2 of 14 residents reviewed for following physician's orders in a total sample of 14. (Residents #31 and #37) Findings include: 1. Resident #37's record was reviewed on 10/31/11 at 12:20 p.m. Resident #37's diagnoses included, but were not limited to, wound to heel, diabetes mellitus, and hypertension. The resident's physician's order, dated 9/30/11, indicated a sliding scale of:	F0282	It is the practice of this facility to provide appropriate services by qualified people to meet the needs of our residents as provided by in their plan of care.Whenever gerisleeves are ordered by a physician, their application will be monitored by a nurse on a daily basis as evidenced by a sign off on the M.A.R.Residents with such orders will have two pair of gerisleeves available to insure when one pair is being laundered, a second pair is available.Direct care staff has been made aware of the importance of frequent review of assignment sheet to make certain all safety measures for residents are in place.Resident #31's gerisleeves were replaced immediately once staff was notified.Skin tears will be discussed and evaluated at the bi-monthly QA meeting to ensure	11/18/2011

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	121-150 = 1 unit 151-200 = 2 units 201-250 = 4 units 251-300 = 6 units 301-350 = 8 units 351-400 = 10 units Resident #37's blood sugar flow sheet, 10/11, indicated the resident's blood sugar was 142 on 10/10/11 at 8 p.m. and 10/16/11 at 4 p.m. The form indicated there was no insulin administered. During an interview on 10/31/11 at 1:50 p.m., LPN #3 indicated the resident should have received one unit of insulin for the blood sugar of 142. 2. Resident #31's record was reviewed on		compliance and effectiveness of current measures in place.Done as of 11/18/2011. ·Resident #37's MAR/Flow sheet was modified to include sliding scale. ·Comprehensive modifications have been made to the MAR to be reflected on the December 2011 MAR's. ·Per in-service on 11/16/2011. ·Parameters and sliding scales already present on the MAR's were added to current flow sheet for affected residents. ·53 of 53 charts reviewed with changes made to affected residents. ·DON or designee three times per week for two weeks, then two times per week for two weeks and then one time per week for two weeks of a random sample to verify effectiveness and adherence to compliance. (See attachment #1). Addendum 2 ·Attached are copies of the modified flow sheets that were put in place on 11/4/2011 to correct the sliding scale parameters for those residents affected. ·The second attachment is the revised MAR that is in place for each resident with parameters for medication administration. Effective 12/1/2011. (See attachments Flow sheet (old) and MAR (new))	

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	11/2/11 at 11 a.m. Resident #31's diagnoses included, but were not limited to, diabetes, hypertension, and dementia with aggressive behaviors. A nurse's note, dated 10/31/11 at 11:30 a.m., indicated "Skin tear noted to left outer elbow...Geri gloves (skin protectors) applied..." Physician's orders, dated 10/1/11 through 10/31/11, indicated bilateral geri sleeves to protect arms. A C.N.A. Assignment List, received from RN #4 as current on 11/2/11 at 11:48 a.m., indicated Resident #31 was to have "geri sleeves to arms." During an interview with CNA #5, on 11/2/11 at 11:35 a.m., she indicated she did not get Resident #31 up that day. She indicated the resident came back from the Dining Room and her geri sleeves were not on and she had received a skin tear. She indicated the resident should have had geri sleeves on. 3.1-35(g)(2)			

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F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview, the facility failed to provide the necessary care and services to residents related to not treating a high blood sugar as ordered by the physician and not applying skin protectant's to a resident, which the resident received a skin tear, for 2 of 14 residents reviewed for care and services in a total sample of 14. (Resident #31 and #37) Findings include: 1. Resident #37's record was reviewed on 10/31/11 at 12:20 p.m. Resident #37's diagnoses included, but were not limited to, wound to heel, diabetes mellitus, and hypertension. The resident's physician's order, dated 9/30/11, indicated a sliding scale of: 121-150 = 1 unit 151-200 = 2 units 201-250 = 4 units 251-300 = 6 units	F0309	It is the practice of this facility to provide necessary care and services for each resident in order to attain or maintain the highest practicable, physical, mental and psychosocial well-being as set forth in each residents plan of care.A modification has been made to the M.A.R. to provide a more comprehensive and efficient record of the physician's order, dosage variables, and administration record. By reducing the number of steps this will increase the accuracy of the medication administration process. Specifically this page will identify the parameters for dosage or medication administration. And will also provide for documentation of the pulse, b/p or the blood sugar obtained by measurement, finally it will document the dosage administered or if the medication was administered or withheld. (See attachment #1).Implementation will be monitored by the DON or designee three times per week for two weeks, then two times per	11/18/2011

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	301-350 = 8 units 351-400 = 10 units Resident #37's blood sugar flow sheet, 10/11, indicated the resident's blood sugar was 142 on 10/10/11 at 8 p.m. and 10/16/11 at 4 p.m. The form indicated there was no insulin administered. During an interview on 10/31/11 at 1:50 p.m., LPN #3 indicated the resident should have received one unit of insulin for the blood sugar of 142. 2. Resident #31's record was reviewed on 11/2/11 at 11 a.m. Resident #31's diagnoses included, but were not limited to, diabetes, hypertension, and dementia with aggressive behaviors. A nurse's note, dated 10/31/11 at 11:30 a.m., indicated "Skin tear noted to left outer elbow...Geri gloves (skin protectors) applied..." Physician's orders, dated 10/1/11 through 10/31/11, indicated bilateral geri sleeves to protect arms. A C.N.A. Assignment List, received from RN #4 as current on 11/2/11 at 11:48 a.m., indicated Resident #31 was to have "geri sleeves to arms."		week for two weeks and one time per week for two weeks of a random sample to verify effectiveness and adherence to new documentation procedure.Done as of 11/18/2011. ·Direct care staff has been made aware of the importance of frequent review of assignment sheet to make certain all safety measures for residents are in place. Resident #31's Geri sleeves were replaced immediately once staff was notified. Skin tears will be discussed and evaluated at the bi-monthly QA meeting to ensure compliance and effectiveness of current measures in place. ·Yes. ·DON or designee to check per signature of MAR ·C.N.A. assignments will continue to be reviewed and updated as needed. Addendum 2 ·The nurses for the dates referenced on the survey have been counseled regarding the insulin for resident #37. ·Nursing staff were in-serviced regarding proper medication administration on 11/16/2011, and the practice of two (2) nurses checking each insulin prior to administration has been implemented to avoid further reoccurrences.	

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	During an interview with CNA #5, on 11/2/11 at 11:35 a.m., she indicated she did not get Resident #31 up that day. She indicated the resident came back from the Dining Room and her geri sleeves were not on and she had received a skin tear. She indicated the resident should have had geri sleeves on. 3.1-37(a)			
F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review and interview, the facility failed to ensure a covered catheter bag was positioned correctly to reduce the risk for infection for 1 of 4 residents with indwelling catheters in a sample of 14. (Resident #23)	F0315	It is the practice of this facility to minimize the use of indwelling catheters unless the resident's clinical condition demonstrates the need for such use.Residents who have catheter bags and are in wheelchairs have had the chairs modified to address the proper application of catheter bag covers.On 11/16/2011 an	11/18/2011

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	Findings include: Resident #23 was observed on 10/31/11 at 11:45 a.m., 12:25 p.m., and 12:45 p.m., up in her wheelchair. The resident's covered foley catheter bag was laying on the floor. Resident #23's record was reviewed on 10/31/11 at 11:55 a.m. Resident #23's diagnoses included, but were not limited to MRSA (methicillin resistant staph aureus) in urine and Alzheimer's disease with dementia. A physician's telephone order, dated 10/24/11 at 3:00 p.m., indicated Resident #23 was to have a foley catheter anchored in place for 10 days due to MRSA in her urine. During an interview on 10/31/11 at 12:55 p.m., with CNAs #8 and #9, the CNAs indicated they did not think it mattered if the covered catheter bag touched the floor because the catheter bag was covered. During an interview on 10/31/11 at 1:00 p.m., LPN #2 indicated the covered catheter bag should not have been on the floor. During an interview on 10/31/11 at 1:15 p.m., LPN #2 indicated the CNAs did not have the straps pulled up for enough to keep the covered catheter bag off the floor. During an interview on 10/31/11 at 1:43 p.m., the MDS coordinator indicated the CNAs are suppose to know the covered catheter bag is not suppose to be on the floor. 3.1-41(a)(12)		in-service was provided for the CNA staff outlining the modifications made to address this issue. The staff was instructed on infection control issues related to a foley bag container dragging on the floor. The CNA noted in the survey has been individually counseled in regarding to this matter. The catheter bag for resident #23 was repositioned immediately after being identified as being in contact with the floor.Catheter bag placement will be monitored by charge nurses and randomly by DON or designee.This is done as of 11/18/2011. ·Check off sheet and walking rounds. ·All applicable shifts. ·Monitoring will continue after six weeks on a random basis to prevent further reoccurrence.	

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	155719	A. BUILDING 00 B. WING	11/03/2011

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GEORGE ADE MEMORIAL HEALTH CARE CENTER	3623 E SR 16 BROOK, IN47922

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F0332 SS=D	The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 1 of 14 sampled residents (Resident #14) and 2 of 5 residents in a supplemental sample of 5 (Residents #36 and #55) observed receiving medications. 5 errors in medications were observed during 41 opportunities for errors in medication administration. This resulted in a medication error rate of 12.19%. Findings include: 1. During a medication administration observation on 10/31/11 at 1:05 p.m., LPN #3 prepared Resident #55's Liquid Tears (eye drops for dry eyes). The label on the Liquid Tears indicated the resident should receive two drops in both eyes four times a day. LPN #3 entered Resident #55's room and administered one drop of Liquid Tears into each of the resident's eyes. During an interview on 10/31/11 at 1:15	F0332	It is the practice of this facility to ensure that it is free of medication errors of greater than five percent.It is now the policy of this facility that medications be administered as per physician order without accommodations or recommendations that may be found in various sources; related to food, amount of dilutent and interactions unless determined by providing pharmacy is to be an absolute contraindication or otherwise specified by ordering physician.Snacks are now available on med carts to be given to residents whose medication orders specify to be given with food.Pharmacy will review and assess for medication interactions or contraindications on a monthly basis.An in-service on 11/16/2011 was provided for Nursing Staff reviewing the six (6) rights of medication administration. An additional in-service will be presented on 11/21/2011, by the Pharmacy Education Nurse addressing medication administration.Medication passes will be audited by Pharmacy education nurse on 11/21/2011 and quarterly audits for medication passes will be held for	11/18/2011

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	p.m., LPN #3 indicated she gave the resident one drop in each eye, she indicated the resident should have received two drops in each eye. Resident #55's record was reviewed on 10/31/11 at 1:15 p.m. The resident's diagnoses included, but was not limited to, dry eyes and hypertension. The resident's last signed physician's recapitulation orders, dated 09/11, indicated an order for artificial tears, instill two drops in both eyes four times daily. 2. During a medication administration observation on 11/01/11 at 7:25 a.m., LPN #2 prepared Resident # 36's medication, which included metoprol (sic) (anti-hypertensive) 25 mg (milligrams), 1/2 tablet. LPN #2 then administered the medication to the resident by mouth. The metoprol's (sic) medication label indicated to give the metoprol (sic) 25 mg, 1/2 tablet twice a day per peg tube (feeding tube). During an interview on 11/01/11 at 7:25 a.m., LPN #2 indicated the resident still had a peg tube. She indicated the label still says to give the medication by peg tube.		the next twelve months.The order for Resident #36 related to administration of medications via peg tube has been changed on 11/21/2011 to reflect future administrations by mouth. The order for resident #14 has been revised to read "Questran may be given with other medications."It was determined by Pharmacy consultation that the amount of dilutent for Questran is considered a minimum. The order has been revised as of 11/9/2011, to read Questran 4 grams to be mixed in a minimum of 60cc H20 or beverage of choice. Medications are now administered per physician order.DON or designee will collect the data of audits/observations and present at the bi-monthly QA meeting for review and follow-up as needed.Done as of 11/18/2011. ·Nursing staff in-serviced on 11/16/2011 regarding proper medication administration. ·Individual nurse counseled. ·Nursing staff in-serviced regarding proper medication administration procedures as applicable to each resident. ·To all applicable shifts.	

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	Resident #36's record was reviewed on 11/01/11 at 8 a.m. The resident's diagnoses included, but were not limited to anorexia, hypertension, and status post peg tube placement. The last signed physician's recapitulation orders, dated 10/11, indicated the resident had an order to flush the peg tube with 250 cubic centimeters every shift, and metoprol (sic) 25 mg, take 1/2 tablet per peg tube two times a day for hypertension. 3. During a medication administration observation on 11/01/11 at 7:30 a.m., LPN #2 prepared Resident #14's morning medication, which included levothyroxine (thyroid medication) 137 mcg (micrograms), potassium chloride (potassium supplement) 20 meq (milliequivalents), and Questron (high cholesterol medication). LPN #2 mixed the Questron with a full glass of water. LPN #2 then administered the medications to the resident without food. The medication labels indicated, levothyroxine 137 mcg daily, potassium chloride 20 meq, one tablet three times daily with food, and Questron 4 gm in 60 ml (milliliters) of water three times a day. During an interview on 11/01/11 at 7:40			

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	a.m., LPN #2 indicated she had mixed the Questron with 240 milliliters of water. An observation on 11/01/11 at 8:05 indicated Resident #14 received her breakfast tray. The resident's record was reviewed on 10/31/11 at 1:55 p.m. The resident's diagnoses included, but were not limited to, hypothyroidism and hypertension. The resident's last signed physician's orders, dated 09/27/11, indicated and order for K-dur (potassium chloride) 20 meq three times daily with food, Synthroid (levothyroxine) 112 mcg and 25 mcg daily. A facility policy, dated 01/07, titled, "SPECIFIC MEDICATION ADMINISTRATION PROCEDURES", identified as current by the Director of Nursing, indicated, "...For liquid medications...dilute in any fluid indicated by the prescriber's order..." A facility professional resource, titled, "Nursing Drug Handbook 2011", reviewed on 11/01/11 at 8:15 a.m., indicated, page 403 "cholestyramine (Questran)...Administration...Mix thoroughly with 60-180 ml of water...Give drug with a meal..."			

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	A facility professional resource, titled, "Nursing Drug Handbook 2011", reviewed on 11/01/11 at 8:15 a.m., indicated, page 1109, "...levothyroxine...Interactions...cholestyramine may impair levothyroxine absorption. Separate doses by 4-5 hours..." A professional resource, titled, "Nursing Spectrum Drug Handbook" 2010, page xiv (14), reviewed on 11/03/11 at 10:30 a.m., indicated, "...The 'five rights' of drug administration...Right patient...Right drug...Right dosage...Right time...Right route..." 3.1-48(c)(1)			
F0371 SS=C	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure 2 of 2 microwaves	F0371	It is the practice of this facility to procure food from approved sources as per Federal, State and	11/18/2011

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	were clean and a carton of expired milk was discarded in 2 of 2 Nourishment Rooms (Main Street and Elm Court). These deficient practices had the potential to effect 55 of 55 residents who reside in the facility. Findings include: During the environmental tour on 11/2/11 at 9:10 a.m., with the Maintenance Director and Housekeeping Director, the following was observed: 1. Main Street Nourishment Room: A. There were dried food splatters on the inside top of the microwave. B. The refrigerator had a carton of milk with an expiration date of 10/30/11. The Maintenance Director indicated he would throw it away. 2. Elm Court Nourishment Room: A. There were dried food splatters on the inside top of the microwave. During an interview at the time of the observation, the Housekeeping Director indicated she was not sure who was suppose to keep the microwaves clean. 3.1-21(i)(1)		Local authority. As well as prepare and distribute food in a safe and sanitary process.The microwaves were cleaned at time of survey.Signs have been affixed to microwaves to remind staff to cover items being heated to prevent splattering.Dietary staff are to clean microwaves each AM.Dietary also checks for expired items in refrigerators each AM.Items are removed as found to prevent further occurences.Dietary and nursing responsible to maintain compliance.Done as of 11/18/2011. ·Microwaves are checked daily by dietary staff. Checks off sheets are reviewed for compliance weekly. (See attached form #2). ·This is ongoing.	

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F0456 SS=F	The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, interview, and record review, the facility failed to ensure laundry equipment was in safe operating condition, related to 3 of 3 linen dryers with a large accumulation of lint build up in the lint traps. This had the potential to effect 55 of 55 residents who reside in the facility. Findings include: During the environmental tour on 11/2/11 at 9:10 a.m., with the Maintenance Director and Housekeeping Director, the 3 linen dryers were observed to have a large accumulation of lint build up in the lint traps. During an interview at the time of the observation, the Housekeeping Director indicated the staff empty the lint traps once every shift. During an interview with Laundry Aide #6, on 11/2/11 at 12 p.m., she indicated she came in at 5 a.m. and will be here until 1:30 p.m. She indicated she had not	F0456	It is the practice of this facility to maintain all essential mechanical, electrical and resident care equipment to be in a safe operational condition.The three (3) dryers have been cleaned and are now scheduled to be cleaned throughout the shift. (See attached form #2 and #3).The dryer lint screen cleaning schedule has been revised.The safety instructions are posted as to proper cleaning of lint and the lint filters.Dryers are maintained per proper procedure and the housekeeping supervisor is responsible to see this is done to maintain a safe environment.Done as of 11/18/2011. ·Dryer cleaning sheets are checked weekly to ensure cleaning process is carried out. ·Housekeeping supervisor is responsible to see this is done; to maintain compliance.	11/18/2011

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	emptied out the lint trap yet. She indicated she does it at the end of her shift. A Dryer Vents Cleaning Schedule Laundry Department form, dated 10/28/11 through 11/02/11, indicated the vents are emptied on the day and night shift. Important Safety Instructions for the dryers, received from the Maintenance Director on 11/2/11 at 10:25 a.m., indicated "...12. Always clean the lint filter before every load..." 3.1-19(b)			